Clifford Molin, M.D. ~ Peter Philander, M.D. ~ Stephanie Lehrner, D.O. ~ Nikki Velasco, FNP ~ Zeeba Sleep Center

Date_____ **PATIENT NO.**_____

PATIENT INFORMATION – INFORMACION DE PACIENTE

PATIENT INFORMATION

PATIENT NAME (LAT, FIRST, MI) – NOMBRE DE PATIENTE (APELLIDO,NOMBRE,MI)				SSN – SEGURO SOCIAL
HOME NUMBER – TELEFONO	SEX - SEXO	DOB – FECHA DE NACIMIENTO	AGE - EDAD	MARTIAL STATUS – ESTADO MATRIMONIAL
ADDRESS – DIRECCION				APT/SPACE/UNIT#
CITY – CIUDAD		STATE – ESTADO		ZIP – ZONA POSTAL
RACE- RAZA __ African American __ American Indian __ Asian __ Pacific Islander __ White		ETHNICITY- ETNICO __ Latino __ Non-Latino		LANGUAGE- LENGUAJE
PATIENT'S EMPLOYER – NOMBRE DEL EMPLEADOR		OCCUPATION – OCUPACION		
EMPLOYER'S ADDRESS – DIRECCION DEL EMPLEADOR				TELEPHONE – TELEFONO
CITY – CIUDAD		STATE – ESTADO		ZIP – ZONA POSTAL

ER

NOTIFY IN CASE OF EMERGENCY	PHONE – TELEFONO	RELATIONSHIP – RELACION	
ADDRESS – DIRECCION	CITY - CIUDAD	STATE – ESTADO	ZIP – ZONA POSTAL

RESPONSIBLE PARTY – REPRESENTABLE DE RESPONSIBLE

RESPONSIBLE PARTY

GUARANTOR NAME (LAST, FIRST, MI) – PERSONA RESPONSIBLE			SSN – SEGURO SOCIAL
ADDRESS – DIRECCION			TELEPHONE – TELEFONO
CITY – CIUDAD		STATE – ESTADO	ZIP – ZONA POSTAL
GUARANTOR EMPLOYER – EMPLEADOR		OCCUPATION – OCUPACION	
GUARANTOR EMPLOYER'S ADDRESS – DIRECCION DEL EMPLEADOR			TELEPHONE – TELEFONO
CITY – CIUDAD		STATE – ESTADO	ZIP – ZONA POSTAL

ER

REASON FOR VISIT – RASON POR SU VISITA	REFERRING PHYSICIAN – DOCTOR DE FREFERENCIA	HOW DID YOU HEAR ABOUT OUR OFFICE?

INSURANCE INFORMATION – ASEGURANZA INFORMACION

PRIMARY INS

PRIMARY INSURANCE CO – PRIMARIA ASEGURANZA		TELEPHONE – TELEFONO	
ADDRESS – DIRECCION	CITY – CIUDAD	STATE – ESTADO	ZIP – ZONA POSTAL
POLICY HOLDER'S NAME – NOMBRE DE EL ASEGURADO	DOB – FECHA DE NACIMIENTO		SSN – SEGURO SOCIAL
RELATIONSHIP TO PATIENT – RELACION CON EL PATIENTE	POLICY HOLDER'S EMPLOYER – NOMBRE DEL EMPLEADOR DEL ASEGURO		
PLOICY NUMBER – NUMERO DE POLIZA	GROUP NUMBER – NUMERO DE GRUPO		EFFECTIVE DATE – FECHA DE EFECTO

SECONDARY INS

SECONDARY INSURANCE CP – ASEGURANZA SEGUNDARIA	TELEPHONE – TELEFONO		
ADDRESS - DIRECCION	CITY – CIUDAD	STATE – ESTADO	ZIP – ZONA POSTAL
POLICY HOLDER'S NAME – NOMBRE DE EL ASEGURADO	DOB - FECHA DE NACIMIENTO		SSN – SEGURO SOCIAL
RELATIONSHIP TO PATIENT – RELACION CON EL PATIENTE	POLICY HOLDER'S EMPLOYER – NOMBRE DEL EMPLEADOR DEL ASEGURO		
PLOICY NUMBER – NUMERO DE POLIZA	GROUP NUMBER – NUMERO DE GRUPO		EFFECTIVE DATE – FECHA DE EFECTO

PHARMACY

PHARMACY- FARMACIA	PHONE NUMBER- NUMERO DE TELEFONO
PHARMACY ADDRESS- DIRECCION DE FARMACIA	FAX NUMBER- NUMERO DE FAX

EMAIL: _____

The above information is complete and correct. I hereby authorize release of information neccessary to file a claim with my insurance company and I assign benefits otherwise payable to me to the doctor or group indicated on the claim. I understand that I am financially responsible for all charges for medical services rendered regardless of insurance coverage. A copy of the signature is as valid as the original.

La informacion obtenida es completa y cortecta. Por este medio usted autoriza el desclosamiento de informacion necesaria al hacer reclamos con mi aseguranza. Tambien asigno benefecios que de otra manera serian pagados a mi a que sean asignados a mi doctor o grupo indicado en el relamo. Yo entiendo de que soy responsible por doctors los cargos relacionados a servicios medicos prestados independientemental tipo de aseguranza.

PATIENT SIGNATURE	DATE	GUARANTOR SIGNATURE	DATE

Health Information and Privacy Act
Release of Patient Information
Patient Authorization Form

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

I _____ give my authorization for Clifford Molin, MD, Peter Philander, MD, Stephanie Lehrner, DO, Nikki Velasco, FNP or Zeeba Sleep Center to use and disclose my protected health information including but not limited to my name or insured's name, name of insurance plan, personal identification number, group or policy number, date of birth, gender, home address, home phone number, legal name, payment information, diagnosis, treatments and procedures, dates and types of hospitalizations, and surgeries. The purpose of the requested use or disclosure is obtaining treatment and healthcare operations, reimbursement, referring to other providers, collection agencies and all other medical or hospital services.

By signing this form you consent to our using and disclosing your protected health information as specified in this authorization. You may revoke this authorization in writing, except to the extent that we have acted in reliance on your prior consent. To revoke this authorization, you must forward a written revocation referencing this authorization to our chief privacy officer at Clifford Molin, MD, LTD.

We may use or disclose your protected health information in the following situations without your authorization. These situation include: as Requested by Law, Public Health issues as requested by law, Communicable Diseases: Health Oversight Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers Compensation: Inmates: Required uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of section 160.500. We are required by law to maintain privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information.

If you choose not to sign this consent, it may be difficult for Clifford Molin, MD, Peter Philander, MD, Stephanie Lehrner, DO, Nikki Velasco, FNP or Zeeba Sleep Center to provide treatment. You will be provided with a copy of this signed authorization upon your request.

Signature: _____

Printed Name: _____

Date: _____

Witness: _____

Clifford Molin, MD ~ Peter Philander, MD ~ Stephanie Lehrner, DO ~ Nikki Solver, FNP ~ Zeeba Sleep Center
2481 Professional Ct ~ Las Vegas NV 89128
Phone: 702-382-1599 Fax: 702-240-4962

Financial Policy

We are committed to providing you with the best possible care. **We must emphasize that as medical care providers, our relationship is with you, not your insurance company. Your insurance is a contract between you, your employer and the insurance company, we are not party to that contract.** All charges are your responsibility from the date of service rendered. We realize that insurance companies need processing time; however, all charges will become due and payable if the insurance company does not reimburse **Clifford Molin, MD, Peter Philander, MD, Stephanie Lehrner, DO, Nikki Solver, FNP** within 90 days or within the guidelines mandated by the NV state Board Bill #SB145.

Please familiarize yourself with your insurance policy and its requirements. Many companies require a referral from the primary care physician. **We will attempt to obtain these as a courtesy; however, the policy holder must be pro-active in assuring the requirements are met prior to the visit.**

If you have medical insurance, with which we are contracted, we will bill your insurance company. All deductibles, co-payments and non-covered items are due at the time of check-in.

Collection Fees Policy: Patient name: _____.
I, _____ (parent /guardian name), hereby agree to be financially responsible for all charges incurred regardless of insurance coverage. In the event my account is referred to a collection service due to lack of payment on my part, I agree to pay all collection / legal fees that may be added to my account.

_____ _____
Signature of patient, parent / guardian Date

Returned Checks: A $25 non-sufficient funds fee will be charges for checks initially returned unpaid by your bank. We repost and forward all returned checks to Clark County District Attorney's office. **INITALS:** ____
No Show Fees: There is a $25 no-show/late-cancellation fee. All appointments must be cancelled by 3 p.m. of the previous day. Insurance will not cover charges for no-show/late-cancellation. **INITALS:** ____
Sleep Study No Show Fees: There is a $200 no-show/late-cancellation fee. All appointments must be cancelled 24hrs prior to your appointment time. Insurance will not cover charges for no-show/late-cancellation. **INTIALS**:

CLIFFORD MOLIN, M.D. ~ PETER PHILANDER, M.D.
STEPHANIE LEHRNER, D.O. ~ NIKKI SOLVER, FNP
2481 Professional Court, Las Vegas, NV 89128
PH (702) 382-1599 FAX: (702) 240-4962

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I hereby authorize the following physician/facility to release my protected health information:

Previous Physician/ Facility: _____

Address: _____

_____

Phone: _____ **Fax:** _____

Information to be disclosed (check all that applies):

☐ **COMPLETE HEALTH RECORDS** ☐ HOSPITAL RECORDS

☐ PROGRESS NOTES ONLY ☐ RADIOLOGY REPORTS & LABORATORY TESTS

☐ OTHER (PLEASE SPECIFY) _____

_____

I UNDERSTAND THAT THIS WILL INLCUDE INFORMATION RELATING TO:

- Human Immunodeficiency Virus (HIV) infection
- Behavioral Health services/psychiatric care
- Treatment for alcohol and/ or drug abuse

Please release the above noted medical records to:

CLIFFORD MOLIN, M.D. ~ PETER PHILANDER, M.D. ~ STEPHANIE LEHRNER, D.O.
2481 PROFESSIONAL COURT
LAS VEGAS, NV 89128
PH (702) 382-1599 FAX: (702) 240-4962

I certify that I have read and upon request will receive a copy of this Authorization. I agree to this release of health information as described herein.

_____ _____ _____
(PATIENT) PRINT (PATIENT) SIGN DATE

DOB: _____ SS#: _____ Contact#: _____

_____ _____ _____
(LEGAL REPRESENTATIVE) PRINT (LEGAL REPRESENTATIVE) SIGN DATE

FAILURE TO PROVIDE US WITH THE ABOVE INFORMATION WILL PREVENT THIS TRANSFER FROM BEING PROCESSED. PURSUANT TO N.R.S. 629.061.1. THERE WILL BE A FEE OF $0.60 FOR ALL RECORDS REQUESTED FOR PATIENT USE.

Comprehensive Medical History

Patient Name: _____ DOB: _____ Age: _____

Main Complaint: _____

Current Medications:

Name of Medication	Dose Strength	Dose Frequency	Prescribed By

Please let a staff member know if you require additional space for medications taken.

Current and/or past major illnesses or medical problems:

Medical Condition	Approximate date diagnosed	Comments

Past surgeries:

Description	Approximate date of surgery	Comments

Allergies: _____

Do/Did you smoke? Y or N If yes, _____ packs per day. If you quit, _____ years ago.

Do you drink alcohol? If yes, type _____ How much? _____ How Often? _____

Family History (check all that apply):

Description	Mother	Father	Sister/Brother
Heart Disease			
Blood Pressure Problems			
Stroke			
Cancer			
Diabetes			
Other_____			

Circle where appropriate: Are you experiencing any of the following?

Fever---chills---tiredness---vision problems---swollen glands---chest pain---difficulty breathing---palpitations---lightheadedness---passing out---ankle swelling---coughing---wheezing---weight loss---weight gain---change in bowel habits---change in bladder control---change in moles---new skin lesions---joint pain---joint stiffness---swollen joints---headache---memory loss---numbness---increased thirst---increased urination---cold intolerance---heat intolerance---irregular periods---missed periods---sexual problems

If not circled, negative.

Please list the most current date for the following:

Pneumonia shot: _____ Tetanus Shot: _____ Mammogram: _____

Colonoscopy: _____ Bone Density: _____ Pap or Prostate exam: _____

SLEEP-DISORDERED BREATHING SCREENING QUESTIONNAIRE

NAME:_____ **DOB:**_____

HEIGHT:_____ **WEIGHT:**_____ **NECK CIRCUMFERENCE**_____**(>16in (15 pts)) AGE:**_____ **SEX: M F**

Are you generally wide awake, energetic and highly motivated all day long? YES NO

EPWORTH SLEEPINESS SCALE

Please answer the following questions based on this scale:

0. Would never fall asleep
1. Slight chance of dozing
2. Moderate chance of dozing
3. High chance of dozing

Situation	**Chance of Dozing**
Reading	_____
Watching TV	_____
Sitting in a public place (e.g. Theater or meeting place)	_____
Driving a car, stopped at a traffic light	_____
As a passenger in a car for an hour without a break	_____
During quiet time after lunch without alcohol	_____
Lying down to rest when circumstances permit	_____

Total Score:_____

Epworth score < 7 = normal, 7 – 15(5 pts) mild risk SDB, 16 – 18(10 pts) moderate risk SDB, ≥ 19(15 pts) high risk SDB.

CLINICAL OBSTRUCTIVE SLEEP APNEA QUESTIONNAIRE

1. Has anyone ever told you that you snore?	YES	NO
If yes, how loud? (Circle one) Quiet (1 pt) Moderate (2pts) Loud (10 pts)		
2. Does your snoring ever bother anyone?	YES	NO
3. Have you ever been told that you stop breathing while you sleep?	YES	NO
4. Do you awaken gasping, choking, or have shortness of breath?	YES	NO
If yes, how often? (Circle one) Occasionally (9 pts) Nightly (14 pts)		
5. Do you have trouble staying asleep once you fall asleep?	YES	NO
6. Do you have morning or daytime headaches?	YES	NO
7. Do you feel tired or fatigued throughout the day?	YES	NO
8. Have you ever nodded off or fallen asleep while driving?	YES	NO
9. Do you have high blood pressure? (5 pts)	YES	NO
10. Do you have heart disease?	YES	NO
11. Do you have indigestion?	YES	NO
12. Have you had any memory loss?	YES	NO
13. Do you ever awaken with intense anxiety?	YES	NO
14. Do you ever experience depressed feelings?	YES	NO
15. Do you notice a decreased ability to think effectively/concentrate?	YES	NO
16. Do you ever take naps?	YES	NO
If yes, how often per week? (Circle one) 1 2 3 4 5 6 7		
16. Do you notice a decreased sexual interest?	YES	NO
17. Do you smoke?	YES	NO
18. Are you overweight? Morbid obesity (5 pts)	YES	NO

Points for responses to the previous questions: yes = 1, no = 0. Based on the patients' responses to the above questions, the RISK of the diagnosis of sleep-disorder breathing (obstructive sleep apnea) is….

LOW	MODERATE	HIGH	VERY HIGH
0-2	3-4	5-8	9-18

Additional Pointing system

- **5-20 points = mild suspicion for Obstructive Sleep Apnea**
- **21-50 = moderate suspicion for Obstructive Sleep Apnea**
- **>50 = high suspicion for Obstructive Sleep Apnea**

DATABANK FORM

If you are interested in participating in future research studies with Clinical Research Advantage, please complete the information listed below.

NAME _____ DATE OF BIRTH ____/____/____

GENDER: ☐ MALE ☐ FEMALE AGE _____

MAILING ADDRESS (Street, City, State, Zip) _____

HOME PHONE:_____ WORK/CELL PHONE:_____

E-MAIL ADDRESS _____

CURRENT MEDICAL CONDITIONS, (Check all that apply)

____ ADD / ADHD
____ Acne
____ Allergies (Seasonal)
____ Alzheimer's Disease
____ Anxiety Disorders
____ Asthma
____ BPH (Benign Prostate Hyperplasia)
____ Birth Control Studies
____ Chronic Bronchitis
____ Cold Sores
____ COPD / Emphysema
____ Constipation
____ Crohn's Disease
____ Dementia
____ Depression
____ Dermatitis
____ Diabetes Type I Type II
Medication: _____
Medication: _____
____ Diabetic Foot Ulcer
____ Diabetic Neuropathy
____ Eczema
____ Enlarged Prostate
____ Erectile Dysfunction / Impotence
____ Fibromyalgia
____ Headaches
____ Cluster Headache
____ Migraine Headache
____ Tension Headache
____ Healthy Patient Studies
____ Heartburn / GERD / Acid Reflux
____ High Blood Pressure
____ High Cholesterol
____ Insomnia / Sleep Disorder
____ Irritable Bowel
____ Joint Pain
____ Low Back Pain
____ Low Libido
____ Multiple Sclerosis
____ Obesity/Weight Loss
____ Osteoarthritis (general)
____ Osteoarthritis (Knee)
____ Osteoarthritis (Hip)
____ Osteoporosis
____ Overactive Bladder
____ Parkinson's Disease
____ PMS
____ Post Menopausal
____ Psoriasis
____ Pulmonary Hypertension
____ Restless Leg Syndrome
____ Rheumatoid Arthritis
____ Smoking Cessation
____ Ulcerative Colitis
____ Urinary Incontinence
____ Vaccine Studies
Other: _____

Benefits of participating in a research study vary, but usually include:

- Study related medical evaluations and medication are provided at no charge to the study participant
- Monetary reimbursement for your time and travel

Requirements of a research study vary, but usually include:

- Additional visits (usually brief) for safety reasons and to evaluate the medication
- Some diary keeping or note taking

By signing this form I am allowing entry of the above personal medical history to be entered into the database of Clinical Research Advantage, Inc. in order that I may be contacted regarding participating in future research studies. This information is considered confidential and will not be distributed in any manner. I have the right to ask to be removed from the database at any time.

_____ _____

Signature Date

Please fax completed form to 702- 990-4339 or mail it to:

Clinical Research Advantage, Inc.
1037 Whitney Ranch Drive
Henderson, NV, 89014